North Dakota Chronic Disease State Plan
Potential Priorities for 2014-2015 –
Definitions of Key Terms and Examples

Instructions:
Below you will find 5 potential state plan activities **in BLUE** that have been suggested by the North Dakota Department of Health chronic disease staff for implementation during 2014-15 on a statewide level across chronic disease partners. We need to further refine this list down to 1 or 2 state plan activity priorities for 2014-2015 and need your input. Please review this document which describes the 5 potential activities with accompanying definitions and examples within the context of the state plan goal they fall under, and be thinking about which of these 5 priorities you think are most important to implement during 2014-2015.

Goal 2: Environmental Approaches that Promote Health and Support and Reinforce Healthful Behaviors

Change policies and environments to enhance personal health behaviors such as physical activity, healthy eating and tobacco-free living.

Rationale:

Traditional health promotion interventions focus on changing individual behavior one or two individuals at a time. Changes in public and organizational policies as well as environmental factors can provide essential support to influence individual behavior and social norms. Since research indicates that improvements in daily physical activity, food choices and exposure to tobacco and its by-products can produce substantial advances in community health, emphasis is placed on these three behaviors in settings where people live, learn, work and play.

Improvements in social and physical environments make healthy behaviors easier and more convenient for North Dakota citizens. A healthier society delivers healthier students to our schools, healthier workers to our businesses and employers, and a healthier population to the health care system. These types of interventions support and reinforce healthy choices and healthy behaviors and make it easier for Americans to take charge of their health. They have broad reach, sustained health impact and are best buys for public health.

Key Terms to understand:

- *Policy and environmental change/factors:*
  Policy and environmental change is a way of modifying the environment to make healthy choices practical and available to all community members. By changing laws and shaping physical landscapes, a big impact can be made with little time and resources. By changing policies and/or environments, communities can help tackle health issues like obesity, diabetes, cancer and other chronic diseases.
    - State level: School recess legislation; defining child care regulations in administrative rules

- Community level: complete streets ordinance; farmers markets ordinances
- Organizational level: breastfeeding friendly policies at the worksite; school wellness policies; creating safe and attractive stairways at a worksite (lighting, painting); bike racks at a worksite

- *Personal health behaviors*:
  An action taken by a person to maintain, attain, or regain good health and to prevent illness. Examples include being physically active, eating a balanced diet, avoiding tobacco, and obtaining necessary vaccinations.
- *Morbidity:*
  The incidence of a disease.
- *Societal costs:*
  The costs related to the loss of productivity caused by absenteeism, disability pensions and premature death.

State Plan Activity 2.1.3: Develop and implement a policy and environmental change plan with strategies that support health and personal health behaviors at the state, community and organizational levels.

Examples of how this might be implemented:

- Develop a written plan that identifies recommended evidence-based strategies at the state, community and organization levels, including the following steps:
  - finalize document of recommended strategies at each level
  - identify stakeholders at each level to implement the strategies
  - distribute recommended strategies to stakeholders at each level, who will prioritize strategies based on feasibility and resources and identify timelines and responsible person/organization

State Plan Activity 2.2.2: Unify communication with stakeholders to coordinate consistent and constructive messaging about policies and environmental factors on personal health behaviors, morbidity and societal costs.

Examples of how this might be implemented:

- Use chronic disease and other related status report (i.e. maternal and child health) to educate legislators and decision makers
- Using existing North Dakota specific fact sheets, develop policy briefs on identified strategies (i.e., school recess, worksite physical activity)
- Identify champions to tell their story about how a policy or environmental change helped them make healthier choices. (i.e. a mom who was able to breastfeed longer because of a workplace policy; an employee who reduced their blood pressure because they were able to use a workplace policy allowing walking on breaks; an employer allows an employee to use work time for tobacco cessation counseling)

Goal 3: Health-Care Systems and Quality Improvement (Health Systems Interventions)

Expand access to and utilization of coordinated, proactive and quality health-care services.

Rationale:

Recent health-care system changes in managing chronic disease involve the move from the traditional specialty clinic-based, symptom-focused and uncoordinated care, to a more comprehensive disease management model of care. Effective use of information and medical technology is one of the strategies the Institute of Medicine recommended to improve the quality of health care in the United States. Access and utilization of high quality health care across the continuum of care must be improved to realize the full potential of prevention and disease management.

Health systems interventions improve the clinical environment to more effectively deliver quality preventive services and help Americans more effectively use and benefit from those services. The result: some chronic diseases and conditions will be avoided completely, and others will be detected early, or managed better to avert complications and progression and improve health outcomes. Health system and quality improvement changes such as electronic health records, systems to prompt clinicians and deliver feedback on performance, and requirements for reporting on outcomes such as control of high blood pressure and the proportion of the population up-to-date on chronic disease screenings can encourage providers and health plans to focus on preventive services. Effective outreach to consumers and reducing barriers to accessing these services is also key, as coverage alone will not ensure use of preventive services.

Key Terms to understand:

- *Health care providers:*
  Health care provider is an individual or an institution that provides preventive, curative, promotional or rehabilitative health care services in a systematic way to individuals, families or communities.
- *Coordination and quality of care:*
  Provide safe, effective, efficient, patient-centered, high quality and equitable care to all.
- *Systems change (in health care setting):*
  Systems change describes specific strategies that health care administrators, managed care organizations, and purchasers of health plans can implement.

State Plan Activity 3.1.7: Convene and assist health-care providers in identifying actions to improve coordination and quality of care and facilitate systems change.

Examples of how this might be implemented:

- Electronic health records with registry function, decision support and electronic reminders.
- Team-based care.
- Systems to ensure adequate follow-up of abnormal screening tests and timely treatment.

- Patient-centered medical and dental home.
- Health care information systems with automated physician prompts or patient reminder letters for screening and follow-up clinical counseling or referral.
- Birthing hospitals using Baby Friendly Hospital Initiative policy recommendations and implementing "Ten Steps for Successful Breastfeeding in Hospitals".
- Delivery of smoking cessation services and treatments-including providing quiltine coaching and cessation treatments as covered benefits.

Goal 4: Personal Health and Self-Management (Community-Clinical Linkages)

Support engagement of individuals in their efforts to reach optimal health.

Rationale:

Individuals empowered with knowledge and skills are capable of making informed decisions about prevention medical care and self-management behaviors across the continuum of life. Their participation, however, depends on how they are engaged in the process of personal health improvement. It is imperative there are multiple, frequent and culturally-appropriate channels for engaging individuals in prevention and self-management strategies.

Community-clinical linkages help ensure that people with or at high risk of chronic diseases have access to community resources and support to prevent, delay or manage chronic conditions once they occur. These supports include interventions such as clinician referral, community delivery and third-party payment for effective programs that increase the likelihood that people with heart disease, diabetes or prediabetes, and arthritis will be able to "follow the doctor's orders" and take charge of their health – improving their quality of life, averting or delaying onset or progression of disease, avoiding complications (including during pregnancy), and reducing the need for additional health care.

Key Terms to Understand:

- *Personal health behaviors*:
  An action taken by a person to maintain, attain, or regain good health and to prevent illness. Examples include being physically active, eating a balanced diet, avoiding tobacco, and obtaining necessary vaccinations.
- *Prevention:*
  Measures to prevent diseases or injuries rather than curing them or treating their symptoms.
- *Self-management:*
  Self-management means the interventions, training, and skills by which patients with a chronic condition, disability, or disease can effectively take care of themselves and learn how to do so.

State Plan Activity 4.1.3: Educate public on the features and benefits of prevention, personal health behaviors, self-management and education services as a means to increase utilization for services.

Examples of how this might be implemented:

- Educate through news releases, social media, physician outlets, and other avenues to inform the public about the benefits of a Diabetes Self-Management Program. Include information about reimbursement options in educational messaging.
- Educate through social media, news release, and other avenues about the benefits of and how to access NDQuits.
- Educate through social media, news releases, and other avenues about cancer screening guidelines, risk factors and strategies to make informed decisions about cancer screening.

Other Notes:

This activity is about promoting the benefits of programs available around the state that educate people about preventing and managing a disease or changing a behavior in order to increase usage of these programs.

State Plan Activity 4.2.5: Connect individuals to prevention, self-management and education services.

Examples of how this might be implemented:

- Educate providers about the Diabetes Self-Management Education programs available and the importance of referring patients to these programs.
- Educate providers on implementation of tobacco use assessment and referral to NDQuits.
- Educate providers on the Optimal Pregnancy Outcome Programs (OPOP), which supports smoking cessation, works with pregnant women that may have gestational diabetes and supports breastfeeding.
- Promote Stanford University's online chronic disease self-management programs to providers so they can refer patients into a program.
- Work with local health care providers to develop a listing of local prevention, self-management and education services that patients can be referred to.
- Develop referral systems with local providers to ease the burden of registration and information-gathering for patients.
- Develop and utilize cancer survivorship programs focused on improving the health of cancer survivors

Other Notes:

The main goal of this activity is to increase awareness about what prevention, self-management, and education services North Dakota has so that they can connect potential participants to these services.